The After-Care of Mental Patients

Henry P. Frost

Massachusetts Society for Mental Hygiene
1916

Simmons College

Library
of the
School of Social Work

After-Care of Mental Patients

BY

HENRY P. FROST, M.D.

DORCHESTER CENTER, MASS.

Superintendent Boston State Hospital, Dorchester Center, Mass.

MASSACHUSETTS SOCIETY FOR MENTAL HYGIENE
1132 Kimball Bldg., 18 Tremont St., Boston

PUBLICATION No. 11

Reprinted from the Boston Medical and Surgical Journal, Vol. clxxiv, No. 15, April 13, 1916.

AFTER-CARE OF MENTAL PATIENTS.*

By Henry P. Frost, M.D., Dorchester Center, Mass.,
Superintendent Boston State Hospital, Dorchester Center, Mass.

After-care of discharged hospital patients was the first effective form of social service undertaken in the field of mental medicine after the accomplishment of proper and reasonably prompt hospital treatment, which replaced almshouse care and other kinds of neglect extending over a long period. Giving assistance and encouragement to indigent and friendless persons dismissed from the hospitals as recovered or improved, which should enable them to get a fresh start in the outside world, presented itself as a practical and much needed philanthropy to many minds before its first formal and organized establishment in this country by the New York Charities Aid Association in 1906.

Dr. William Mabon of New York, in a paper published in 1907, reviewed the earlier efforts in this direction of Dr. Wise of New York, Dr. Dewey of Illinois, Dr. Stedman of Massachusetts, and others, as individuals or as members of committees appointed by interested organizations, and relates the whole history of the movement from its inception in the early nineties until it crystallized into action under the wise direction of Miss Louisa Lee Schuyler, a leading spirit in the New York organization referred to.

Begun on humanitarian grounds, for the benefit of individuals, after-care was early recognized to be an important item in any comprehensive program for prevention of mental disease, for, unfortunately, mental disease is very prone to recur, and if after-care of recovered patients can avert even a small proportion of subsequent attacks, its value is demonstrated. Utilized, as it should be, to dissuade recovered patients from marriage, and, in the case of the married, from further child rearing, it attacks the problem of mental disease at the best possible point—its source; and through safeguarding other members of families already invaded and their connections and friends, as is in a manner possible, the influence for good of such a system may well be incalculable.

In Massachusetts a wise provision in the insanity law, which permitted the discharge of patients on six months' probation, and which had for several years been widely used by the hospitals, was extremely

*Read before the Conference of the Massachusetts Society for Mental Hygiene, Ford Hall, Boston, Nov. 18, 1915.

helpful when it came to organizing systematic supervision of discharged patients, and their assistance. This trial period covers the most critical time, both as regards the stability of the patient's mental condition and the difficulties in the way of social and financial rehabilitation, and the facility with which further hospital treatment may be obtained at will, or in case of need be enforced with ample authority, tends to simplify many of the problems which arise in this extra-mural work of the hospitals, and gives it an effectiveness far greater than if it were dependent upon voluntary coöperation alone, like the social work of the general hospital.

In France and England, where this matter of after-care received attention earlier than in this country, it has been carried on by volunteer societies, supplying funds and workers and coöperating with hospital officials. To some extent the same plan has been adopted in this country, such organizations as the State Charities Aid Association in New York and the Societies for Mental Hygiene in various states taking it up as a part of their program, but in general it has been thought that this is work which can best be done directly by the hospitals through the agency of trained social workers, devoting their whole time to this and other forms of social work, articulating it closely with the intramural treatment and making the record of each case a part of the hospital case record.

This is the method followed in our state, where, under the stimulus of the State Board of Insanity, which has been keenly interested in developing this phase of hospital work, each institution caring for the insane and the feebleminded has its social worker or its corps of workers assisting the medical staff in their dealing with patients and their families for the settlement of social problems both before and after discharge,—securing data for social and medical history of cases admitted, inspecting homes and employment possibilities previous to discharge of patients, maintaining supervision for after-care and taking part in the work of the out-patient clinics where these are conducted.

The official status which this plan gives to after-care of our patients has certain advantages and also some drawbacks. The visitor enters a home with accurate knowledge of the history of the case, with the additional advantage of a personal acquaintance with the patient, obtained at the hospital, and in many cases already known to the family through her interest shown on behalf of the patient at an earlier stage of the treatment, perhaps having to her credit the helpful solution of some domestic problem brought about by the illness of the member now returning to the family circle. Furthermore, she is trained and experienced, equally at home in the hospital ward, the

wage earner's tenement or the employment office, accustomed to contact with mental derangement, and possessing the point of view of the medical officers whose agent she is in this work.

On the other hand, she may appear to the former patient or to his family as an official spy, a representative of an organization which has wrought injustice by confining him in an institution—for not all recovered patients have complete insight regarding their illness—and her presence may be resented as a visualized threat of further confinement. This is one disadvantage that confronts the hospital social worker. Then again she is but one—or let us say two or three—where perhaps a dozen would be engaged were it not for difficulties connected with the budget; and finally—also for fiscal reasons—her resources for giving material aid are sharply circumscribed. Therefore, to make the after-care effort effective, to even approach in realization the widespreading possibilities for good which it clearly opens to our view, the coöperation and assistance of the community organizations for relief and social welfare are necessary; and an important function of our social workers is to connect with the proper agency and in this way secure continuance of the supervision in cases requiring prolonged attention, and also in cases where particular needs of the patient or the family can best be met by this method of specialization. In addition, though, to this extension of official or semi-official aid, there is great need for the help of individuals. The best possible help and encouragement that any person in trouble or distress can have is that which comes from a friend. Therefore, the hospital's task in after-care is most satisfactorily accomplished in those cases in which it is possible to interest and suitably instruct friends already existent, or else to find and make for the patients new friends who will extend a helping hand to them.

For the individual patient this is possible in a variety of ways, notably through church and neighborhood affiliations, through the family physician, the employer or the fellow employee. For the group, such expositions of the work and the need as we are now attending should operate to make friends and helpers. A better understanding on the part of the public of the nature of mental disorders, their causes, their course and results, will lead to a different attitude toward the returned patient and a lessening of the distrust with which he is habitually regarded and which is one of his heaviest handicaps and chief causes of discouragement and failure. I hope I may be wrong, but I venture the belief that no large proportion of the householders present would willingly receive into their domestic service on our recommendation recovered patients, but I am confident that you would do

so after visiting the convalescent wards of a mental hospital, or if you could see even the unrecovered patients, of whom several hundred are living contentedly in family care under supervision of the state.

So much for general principles and plea for interest. Specifically, what are the needs of a recovered patient,—in what way do our organizations for after-care meet these needs, and what is the measure of the work they are doing? First, we must consider that a mental illness is, in general, a prolonged illness, that it involves a serious outlay which is often unwisely borne by the family in an effort to avoid treatment in a public hospital, owing to the feeling that a stigma is thereby incurred, and also to a still existent prejudice—founded on ignorance of what the hospitals really are. Or if but little actual expense has been incurred, the visitation of mental disease has curtailed the family income,—often obliterated it. As a result, when, after months of treatment, recovery finally takes place, the prospect that faces the patient is return to a world that has for him sadly changed. He has to find employment anew, pay off debts, reëstablish his home. Still lacking strength, perhaps, with confidence impaired and sensitiveness increased, he has to face the most difficult situation of his life, while as yet but ill prepared for even ordinary trials.

Or it may be that the difficulty to be overcome on returning home is less financial than one of temperament or of temptation to be resisted. The home may have been unhappy, the neighborhood uncongenial, habits detrimental. The case may be that of a wife and mother whose problem is to resume the care of her household, to get her children back from temporary homes, or to remedy conditions due to their faulty supervision during her illness, or to eliminate a housekeeper or relative installed in her place; or the patient may be one without home or family as well as without employment; and any of these may, after mental recovery, still be in need of medical care, of nursing, diet, of a country vacation. All of them are certainly in need of advice based, not only on knowledge of the case itself, but of the surrounding conditions—hence advice which the hospital physician cannot supply unaided, and which would, in most cases, be little heeded in any event unless backed up with supervision and reiteration, and, finally, they need encouragement, and in many instances substantial aid of one sort or another.

Another general need is that these discharged patients be kept in close and friendly touch with the hospital and in readiness to apply there again at any time for counsel in the event of threatening symptoms recurring,—a disposition which is greatly encouraged by the intimate contact maintained through after-care supervision.

An attempt is made by our social workers to meet these needs, and many others which I have not specified, by first investigating the homes and the conditions to which it is proposed that a patient shall return, or by finding a home for those without one, and creating conditions which promise well and getting assurance of employment or of suitable support, as well as of reasonable supervision and coöperation in the after-care by relatives or friends, or from any available source.

Upon being dismissed from the hospital on trial a definite understanding is had with the patient and with his sponsor, the arrangement varying according to circumstances, but in general an early report in person at the hospital is exacted, this to be repeated at intervals, usually of one month. A patient keeping such an agreement, and evidently doing well, is visited at home but seldom, perhaps only once, and sometimes not at all where conditions are known to be satisfactory and the family coöperative, but failure to report brings about a visit from the social worker, who then continues the home supervision.

This combination of home and hospital visits enables the staff to supervise a large number of patients during the trial visit, without requiring a larger force of visitors than it is practicable to have, and while it may be truly said that actual conditions are best seen in the home on unannounced visits, the return to the hospital has the advantage of bringing the patient actually before the doctor for observation, and if judiciously mixed with home visits it is the most satisfactory plan. Unfortunately, it is not so feasible in the other hospital districts as it is here in Boston, but the hospitals serving the more scattered districts have now provided for this kind of supervision by establishing out-patient clinics at convenient points in their territory, where the physicians attend at stated times for the purpose of seeing former patients, as well as new cases presenting. I may speak here of a very helpful relation established through the custom of having discharged patients return to the hospital. They usually include the wards in their visit, greet the friends they left behind, encourage these by demonstration of their own recovery and well-being, and in not a few cases assist others in arrangements for discharge and employment, etc.

Former patients often continue outside the friendship formed at the hospital, and thus little social centres of mutual helpfulness are created. A men's club composed of recovered patients who need help in their fight against the drink habit meets regularly at the Psychopathic Hospital and has proved valuable to many members, and it is a frequent and pleasing occurrence in all the hospitals that former patients attend the dances and other social gatherings.

The technique of the home visitor cannot well be described in detail, being so diversified to fit the wide range of conditions encountered. It is sufficiently indicated in what I have already said about the adjustment of the environment, instruction in bodily and mental hygiene and securing of material aid to the extent possible.

The annual discharges from the public hospitals for the insane in this state are, in round figures, 2,000. A very large proportion of these patients are supervised for a period of six months, and many for longer periods, in the ways described,—not successfully in all cases by any means, but assuredly with a benefit to individuals and to the community, not to be measured by the cost of the service or by any statistics that might be compiled to show it.